Journal of Family Strengths

Volume 14 | Issue 1 Article 4

12-31-2014

Development and Evaluation of the Family Asset Builder: A New Child Protective Services Intervention to Address Chronic Neglect

Tyler W. Corwin
Casey Family Programs, tcorwin@casey.org

Erin J. Maher
Casey Family Programs, emaher@casey.org

Monica Idzelis Rothe
Amherst H. Wilder Foundation, monica.idzelis@wilder.org

Maggie Skrypek
Amherst H. Wilder Foundation, maggie.skrypek@wilder.org

Caren Kaplan
Innovations in Child Welfare, caren@ckinnovations.org

See next page for additional authors

Recommended Citation

Corwin, Tyler W.; Maher, Erin J.; Idzelis Rothe, Monica; Skrypek, Maggie; Kaplan, Caren; Koziolek, Dan; and Mahoney, Brenda (2014) "Development and Evaluation of the Family Asset Builder: A New Child Protective Services Intervention to Address Chronic Neglect," *Journal of Family Strengths*: Vol. 14: Iss. 1, Article 4.
DOI: https://doi.org/10.58464/2168-670X.1244
Available at: https://digitalcommons.library.tmc.edu/jfs/vol14/iss1/4

Development and Evaluation of the Family Asset Builder: A New Child Protective Services Intervention to Address Chronic Neglect

Acknowledgements

We would like to thank Debra Gilmore, previously Child Protection Reform Manager at the American Humane Association, for her contributions to the development of the Family Asset Builder model. We would also like to thank the Family Asset Builder staff and supervisors for sharing their insights about the intervention model for the purposes of the evaluation. Special thanks to John Fluke, also previously with American Humane Association, and Peter Pecora at Casey Family Programs for contributions to the conceptualization of this project. Finally, we would like to acknowledge both counties' willingness, foresight, and leadership in taking on this innovative pilot project.

Authors

Tyler W. Corwin, Erin J. Maher, Monica Idzelis Rothe, Maggie Skrypek, Caren Kaplan, Dan Koziolek, and Brenda Mahoney

Development and Evaluation of the Family Asset Builder: A New Child Protective Services Intervention to Address Chronic Neglect

Neglect, the most pervasive type of maltreatment in the United States, is typically defined in state law "as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm" (Child Welfare Information Gateway [CWIG], 2012, p. 2). Based on the most recent national estimates, the vast majority of child maltreatment victims—more than 530,000 children—suffered from neglect. Furthermore, 70 percent of all child fatalities involved neglect either alone or in combination with other forms of maltreatment (U.S. Department of Health and Human Services [USDHHS], 2013). Since the year 2000, rates of sexual abuse and physical abuse among maltreatment victims have remained relatively unchanged (approximately 10 percent and 19 percent, respectively), whereas rates of neglect have drastically increased from 63 to 78 percent (USDHHS, 2000; 2013).

Beyond its ubiquity, neglect differs from other forms of child maltreatment in terms of its definition and manifestation as well. Rather than the commission of an act (e.g., physical abuse) that warrants an investigation by Child Protective Services (CPS), neglect involves the omission of action on the part of caregivers, often over an extended period of time, to provide for a child's basic physical, emotional, supervisory, medical, or educational needs (Australian Office for Children, Youth and Family Support, Community Services Directorate, 2010; CWIG, 2012; Turney & Tanner, 2001). Contrary to other forms of abuse, neglect often "occurs without intent to harm" and is symptomized by a lack of nutrition, energy, hygiene, appropriate clothing, medical aids (e.g., eyeglasses), or medical care (Pekarsky, 2014). Further, neglect often occurs in combination with parental substance abuse (Carter & Myers, 2007), domestic violence (Osofsky, 2003), economic hardship (Shook Slack, Holl, McDaniel, Yoo, & Bolger, 2004), or numerous other complex family challenges (Copps Hartley, 2002). For these reasons, neglect can also prove more difficult to define and identify than other forms of maltreatment (Gaudin, 1999; Hearn, 2011), which poses a barrier to effectively drawing attention to this concerning form of child maltreatment and prevention efforts.

Neglect is also more likely than other forms of maltreatment to occur repeatedly in families who have a history of maltreatment (DePanfilis & Zuravin, 1999). Families reported to CPS for neglect tend to

be reported multiple times when new issues or problems arise because of the complex array of family characteristics commonly associated with *chronic neglect*, which can include poverty, mental health, substance abuse, lack of social support, and chaotic family and community environments (CWIG, 2013). In this vein, chronic neglect is defined as a parent or caregiver's "ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs" necessary for healthy growth and development (Kaplan, Schene, DePanfilis, & Gilmore, 2009, p. 1). Because families reported to CPS for neglect and families with multiple prior reports are more likely to be re-reported for child maltreatment, and often at shorter intervals, drawing attention to the problem of chronic neglect is paramount (DePanfilis & Zuravin, 1998; Marshall & English, 1999; Zuravin & DePanfilis, 1996). It is a developmental issue characterized by recurrence and duration (CWIG, 2013; Gilbert et al., 2009; Steib & Blome, 2009). The impact of chronic neglect is cumulative over time and can seriously impair physical, cognitive, and social and emotional development (CWIG, 2012, 2013; Hildyard & Wolfe, 2002; Smith & Fong, 2004; Tyler, Allison, & Winsler, 2006), particularly when it occurs early in the child's life (Perry, 2001). A recent working paper from the National Scientific Council on the Developing Child (NSCDC; 2012) documents the impact of neglect on brain development as a mechanism for these devastating long-term impacts.

Despite the pervasiveness of neglect and the established deleterious consequences, relatively little attention is paid to neglect compared to that of physical and sexual abuse (CWIG, 2012; Erickson & Egeland, 2002; NSCDC, 2012; Wilson & Horner, 2005). While tragic or shocking cases of child physical or sexual abuse often receive publicity, neglect frequently goes unreported and underpublicized (DePanfilis, 2006). Dubowitz (1994) cites several reasons for the lack of attention paid to neglect, including the belief that consequences of neglect are less serious, the problems related to neglect are too difficult to solve, parents should not be judged for "poverty-related" neglect, and the definition of what constitutes neglect is too vague (as cited in Miller-Perrin & Perrin, 2013, pp. 151-152). As discussed, the consequences of neglect and chronic neglect can be severe, however, and warrant increased attention from child welfare agencies, the public, and researchers.

Interventions specifically designed to target neglect and its harmful effects are lacking, as well as evaluation studies that assess the effectiveness of such interventions (Altshuler, Cleverly-Thomas, & Murphy, 2009; Dubowitz, 1994; Klevens & Whitaker, 2007). In fact, of the

more than 330 programs that serve children and families documented on the California Evidence-Based Clearinghouse for Child Welfare [CEBC], only 5 are classified as *Interventions for Neglect* (CEBC, 2014). Of these, only three have studied program implementation among neglecting families and have a scientific rating of research evidence: Homebuilders, Family Connections, and SafeCare (Bath & Haapala, 1993; Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012; DePanfilis & Dubowitz, 2005). More sustained and broad-ranging approaches to working with these families are needed, in addition to research that informs practice and policies in this area.

Further, current child welfare service models may not be appropriate for caregivers who chronically neglect children (Chaffin, Bard, Hecht, & Silovsky, 2011), as the needs of these caregivers often lie beyond immediate child safety considerations (Bath & Haapala, 1993; Gardner, 2008; Nelson, Saunders, & Landsman, 1993). Many service models and prevention efforts fail to attract and retain families, to integrate program strategies across family circumstances, to offer a clear conceptual framework, to engage families with a sufficient dosage and duration, and to maintain fidelity throughout implementation (Daro, 2009). Interventions targeting chronic neglect, for example, may require an extended service duration of 12 months or more and strategies to meet families' basic needs prior to other services, such as parenting education (American Humane Association, 2010). Given the familial and ecological context wherein neglect occurs and the probability that such neglect will be repeated over time, interventions that target chronic neglect require considerations beyond typical service provision.

The unique nature of neglect, its prevalence, and its harmful effects require the development of specialized interventions, strategies, and tools to assist families with raising children in safe and healthy environments; however, the issue of child neglect is often underpublicized and interventions addressing neglect are scant and infrequently evaluated with rigor. To address this gap, a few public child welfare jurisdictions are implementing smaller, innovative reforms to tackle this problem (CWIG, 2013). This article describes the development of one such intervention approach to address this enduring social problem. The authors illustrate how a developmental approach, modeled after the Institute of Medicine's (IOM) Prevention Framework, can be used to inform the implementation of a model for chronic neglect and establish its viability prior to establishing its effectiveness in a larger context.

Method

Evaluation Approach

A recent issue of this journal described the need for intervention specification and practical strategies around implementation when assessing sustainability and replicability, especially during an intervention's developmental phase (Alameda-Lawson, Lawson, & Lawson, 2013). As described by the National Institutes of Health in relevant funding announcements, intervention development is comprised of three stages: (1) using theory, empirical data, and research to conceptualize and design an intervention, (2) developing and standardizing the intervention, and (3) pilot testing. These steps are consistent with the first three of five steps in the IOM preventive research cycle to establish an evidence-based program. These first three steps include identifying the problem, reviewing relevant information on other interventions, and designing and piloting studies. The final two steps outlined by the IOM, after confirmatory pilot data have been collected and analyzed, include large-scale program implementation and outcome evaluations (IOM, 1994).

A mixed-method, multiple perspective, and "situationally-appropriate" (Britt & Coffman, 2012) evaluation approach was used for each of these first three steps in the IOM process. As recommended for the earliest stages of implementation, the evaluation involved multiple stakeholders (funders, service providers, and the program developer) in all phases of the evaluation, and both the evaluation approach and intervention development were responsive to early evaluation results (Adams, 2003; Millett et al., 1998). Consistent with intervention development research, feedback from service providers and other stakeholders was encouraged to inform deviations from and improvements to the original model (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment [NAMHC], 2001). The evaluation was exempt from Institutional Review Board review by the State of Minnesota under the exception for evaluation of public service programs; however, all data collection processes and instruments described below were reviewed and approved by Casey Family Programs Human Subjects Review Committee.

The Intervention

In 2009, Casey Family Programs and American Humane Association (AHA) came together to address the problem of chronic

neglect. Per the aforementioned intervention development framework, the project team developed the model based on AHA's expertise in and extant literature on chronic neglect. For example, caregivers who chronically neglect their children often have long-standing, complex issues which require interventions that use the tenets of social support: a focus on concrete supports, educational support through knowledge and life skill development, emotional support, and social integration (Cameron & Vanderwoerd, 1997). Additionally, an intervention targeting chronic neglect should apply an ecological framework, which considers family needs within the context of social and psychological influences (Ethier, Couture, Lacharite, & Gagnier, 2000). At the family level, caseworkers should focus on and develop family strengths, as opposed to focusing on problems or the incident that brought the family to the attention to CPS (Steib & Blome, 2009). Caseworkers should also empower families to tackle their challenges independently and should develop partnerships with families to foster engagement, communication, and trust (DePanfilis, 2006).

Building on this theoretical basis and insight provided by child welfare agency staff and stakeholders, AHA produced a framework outlining six elements of an intervention for effectively working with families involved with CPS due to chronic neglect: (1) meet the concrete needs of the family first, (2) build a trusting relationship with the family, (3) develop family skills through small, measureable goals, (4) strengthen the family's support network, (5) work with the family for more than 12 months, and (6) use caseworker teams and practice self-care to avoid caseworker burnout and secondary trauma (AHA, 2010, p. 4). Using these tenets as a guide, the following describes the major components of the Family Asset Builder (FAB) intervention model, which was developed out of AHA's framework for addressing chronic neglect.

The FAB model uses the knowledge that families experiencing chronic neglect do not respond to child welfare's incident-oriented approach and targets the persistent pattern of parental and familial behavior that underlies neglect. FAB does not utilize a new clinical or practice model, though one unique aspect of the model is the funding provided for families' basic needs; instead, it is a staff specialization and engagement model, with strengths-based, intensive monitoring of short-term goals using typical casework practice. Table 1 describes these and other core components of the FAB model. The FAB intervention takes an ecological perspective, meaning that the needs of each child must be understood not only in the context of his or her family, but also in the context of the community in which he or she lives and the family's

connections within that community. FAB targets the chronic nature of neglect in families and recommends a structural and systems approach for child welfare agencies.

Table 1: Family Asset Builder model components[a]

Structural Components	
Staffing levels/ characteristics	Dedicated chronic neglect caseworkers ◆ Workers possess competency-based knowledge of chronic neglect and the skills needed to engage, support, and assist families that regularly neglect their children.
Caseload	Six to eight families per worker ◆ Worker is assigned to the family for the life of the case (report assignment through closure).
Supervisory structure	One supervisor dedicated to supervising chronic neglect case workers and oversight of chronic neglect cases
Intervention duration	Recommended 18 months of service provision with three- and six-month "boosters" (i.e., follow-up visits after closure to check on family well-being and service or supportive needs)
Frequency and duration of contacts	Minimum of two contacts per week with the whole family ◆ Minimum of two contacts per week with primary caregivers (preferred contact method is face to face)
Process-Related Components	
Values	Believe that all families have strengths and resources ◆ Value the strengths and resources of families as tools that help families keep their children safe ◆ Strive to understand and work with families in the context of their culture and environment ◆ Treat family members as partners ◆ Recognize that services that meet child and family needs are based on safety concerns and risk of maltreatment ◆ Provide frequent, consistent, and long-term intervention to families impacted by chronic neglect to instill hope, systems of support and sustained change
Guiding principles	Child safety comes first. ◆ All policies and practice are child-centered, family-focused, and community-based. ◆ Intervention in the lives of families is commensurate with the family's needs. ◆ Family engagement and partnership are core components of effective intervention with families in need of services and support. ◆ Families have the right to make their own decisions and choices unless the child's safety is compromised.
Emotional climate of organization	Parallel process: Strengths-based, solution-focused ◆ Transparency ◆ Flexibility ◆ Supportive/collaborative
Practice-Related Components	
Screening criteria (required for eligibility)	Current report screened in for neglect ◆ At least two prior reports (whether screened in or not) within past three years; reports must be at least one month apart to reflect separate incidents ◆ At least one child under age five in household ◆ At least one prior report resulted in a finding of substantiated maltreatment or services needed.
Staff-client interactions and decisions	Family interactions are strengths-based and solution focused. ◆ Workers facilitate solution-building in partnership with the family to create small, measureable, and achievable goals ◆ Decision-making is driven by family choices and those decisions are honored unless the child's safety is compromised.
Pathway	Family assessment or family investigation (pathway is noted in the case record)
Voluntariness	Assigned families do not have the option to refuse CPS services, but service plan is family-led (hybrid of investigation and assessment).
Worker self-care	Identification of "red flags" that are indicative of burnout and/or secondary trauma[b]

[a] Table format adapted from James Bell Associates (2009).

[b] *Secondary trauma*, often referred to as *vicarious trauma* or *compassion fatigue*, is defined as a physical and emotional stress response to working with a highly traumatized population. It is a psychological phenomenon in which the

professional helper and/or caregiver experiences many of the common feelings and symptoms associated with victimization (McCann & Pearlman, 1990).

The basic components of the FAB model are the use of a strengths-based and solution-focused approach with dedicated chronic neglect social workers and supervisors who have the requisite skill set and experience to work with this target population. Each worker carries a reduced caseload of six to eight families and works with families over an extended period of time. The social workers meet with the family at least once per week and contact the primary caregiver at least twice per week (preferably face-to-face) over 18 months, which constitutes a duration and intensity greater than typical casework, but appropriate for the complex needs of these families (Wilson & Horner, 2005; Macdonald, 2001). Initial eligibility to participate in the FAB intervention included the following criteria: the current report (i.e., allegation) screened into the child welfare agency is for neglect; the family has at least two prior maltreatment reports (whether screened in or not) within the previous three years; at least one child in the household is under age five; and, at least one prior report resulted in a substantiated maltreatment or services-needed finding.

Casey Family Programs and Wilder Research (Wilder), a Minnesota-based research and evaluation firm, conducted the evaluation. The project team identified two counties in Minnesota, Stearns and Carver, as ready and willing to pilot the newly developed FAB intervention model. Researchers conducted focus groups with caseworkers and supervisors in each of the two counties to gain context on experiences working with families with ongoing neglect reports and to gather input about their respective agency's strengths, barriers, and solutions for working successfully with this group of families. The project team also analyzed administrative child welfare data from 2000 to 2010 from one participating county to assess what constitutes chronic neglect, to identify patterns in the timing of neglect reports, and to note whether there were distinguishing characteristics among children with more than one neglect report compared to children with other types of reports. For example, in one participating county (and Minnesota at large), over 60 percent of the child protection assessments conducted the year preceding the FAB intervention were for allegations of neglect, and over 35 percent of children whose families were involved with CPS in that county and year had at least one subsequent substantiated maltreatment report (County agency representative, personal communication, October 29, 2014; USDHHS, 2011). Further, project staff conducted a review of existing screening tools and relevant literature to inform the development of the initial screening criteria and the core components of the FAB intervention.

FAB training of community partners and agency staff consisted of three components. The first component involved a half-day training in each county for community stakeholders, which provided an overview of the issue of chronic neglect and the FAB intervention model, with the hope of securing community understanding and buy-in. This session was open to the larger community that collaborates with CPS and included law enforcement, county attorneys, guardians ad litem, school social workers, hospital social workers, therapists, and other community providers. The second component, also a half-day training session in each county, was targeted to social service staff (e.g., social workers in child protection, children's mental health, truancy, adoption, and foster care). Fifty-three county workers attended the community forums and 35 staff attended the social service staff training (across both counties).

The third training component was a more in-depth training on the FAB model for only those staff involved in its implementation. (FAB staff also participated in the community and social service staff trainings.) This training was attended by FAB social workers, supervisors, and division directors from both pilot counties (nine staff in total). In addition to the structural components of the FAB model, the training focused on valuing the strengths and resources of families as tools to help keep their children safe, understanding the unique challenges of working with families in the context of their complex environments, treating family members as partners in decision-making (unless a child's safety was compromised), and maintaining a strengths-based/solution-focused approach. Furthermore, because of the frequency of contact between FAB workers and families, solution-building focused on small, measureable, and achievable goals.

Data Collection

Phase I: Pre-implementation. This phase of the evaluation had three components and was primarily designed to understand the policy and practice context for implementation of the model and to evaluate the training on the model. First, in December 2010, Wilder conducted semi-structured telephone interviews with the two county leaders (one director, one manager) from each pilot county overseeing this project. Wilder interviewers asked county leaders a series of questions about how their county became involved with the project, how chronic neglect cases are currently handled in their county, their expectations of the new program, and potential barriers to success. Second, the project team recorded detailed notes from each of the FAB training sessions. Lastly, ten days following the final training session, Wilder staff invited all training

DOI: 10.58464/2168-670X.1244

attendees to complete an online survey about the FAB intervention and the training. The purpose of the survey was to assess participants' understanding of the intervention, their expectations, and any questions they had following their participation in the training. Participants were given one week to complete the survey and received one reminder email following their initial invitation. (In all, 31 of 79 participants completed the survey for a response rate of 39 percent.)

Phase II: Early implementation. In February 2011, Carver and Stearns Counties launched the FAB model. Both counties' child welfare agencies were expected to shift worker caseloads in order to permit specialized FAB workers to work with a smaller number of families. This phase of the evaluation involved two components designed to understand how the model was being implemented from the start and what improvements to the model needed to be made, if any. First, in October 2011, Wilder staff conducted semi-structured telephone interviews with child welfare agency staff participating in the pilot project (three caseworkers, three supervisors, and two county leaders). Wilder interviewers asked FAB staff a series of questions about their perceptions of the pilot project including their understanding of the model; benefits of and challenges to working with families; impact on staff, families, and their organizations; and, their hopes for the future. Second, between February 2011 and November 2012, 15 consultation calls were held with the project team. The purpose of the calls was to discuss implementation successes and challenges, consult with the program developer and content expert, share feedback and insight to assist colleagues in their work, and identify opportunities to improve or enhance the model as it was being implemented.

Phase III: Final pilot year. The final phase of the evaluation of the FAB model consisted of two components, in addition to the ongoing use of the consultation calls, as described above. First, in October 2012, Wilder staff conducted semi-structured telephone interviews with families who had participated, or who were actively participating, in FAB. The interviews involved primarily open-ended questions that addressed the parent's relationship with his or her FAB worker, including the quality of his/her relationship with the worker, his/her level of contact with the worker, his/her relationship with past CPS workers (relative to his/her experience with FAB workers), perceived program impact, his/her future outlook, and the workers' knowledge of the family. Additionally, the interview included a series of items that asked parents to rate their caseworker in several

areas to assess satisfaction and program fidelity. Second, the project team asked FAB caseworkers at each site to complete tracking logs for each of the families. These logs included case-level information on household and child demographics, case status with the FAB intervention, family history with CPS, re-reports of child maltreatment, and out-of-home placements for the children during the time period of the study.

Data Analysis

Project staff reviewed and summarized notes from the interviews with county child welfare leaders, FAB workers and supervisors, and FAB-participating families, as well as observations from the FAB training sessions. Further, members of the project team transcribed each of the consultation calls. For the interviews, staff summarized open-ended responses by question and used these summaries to develop a coding scheme. Project team members combined responses to questions addressing similar content areas in the coding phase if they identified the same themes across questions. Project staff used descriptive statistic techniques to analyze data from closed-end questions and the online survey. Analysis of the transcriptions used a pragmatic, thematic analysis approach, similar to steps described by Aronson (1994) and Hsieh and Shannon (2005), where themes are identified and categorized from the data. Lastly, the project team used information from the tracking logs to describe the participating families, length of service with the FAB model, and ongoing involvement with CPS.

Results

The results from all three phases of the evaluation are organized into the following sections associated with the phases of data collection listed above: Pre-Implementation, Early Implementation, and Final Pilot Year. For each topic area, the authors discuss specific ways the evaluation was used to support the model development process and any recommendations that stem from these findings.

Pre-Implementation Results

The pre-implementation phase of the evaluation provided necessary context for the roll-out of the intervention and to inform improvements in the model (including the training). Prior to FAB, the counties' response to chronic neglect cases was similar to their response to other types of cases (i.e., workers did not specialize in a particular type of case, so all workers likely had some chronic neglect cases on their caseload). While the counties were not receiving any financial resources

to implement the model, leaders from both counties identified benefits of participating in the pilot, including access to research on the topic of chronic neglect, training, and opportunities to discuss and reflect upon lessons learned throughout the project, which they believed would have a positive effect on cases outside of the program as well. One county leader noted that the model would allow them to standardize strategies they believed were effective and that many caseworkers already used. Agency leadership noted the major difference between business-as-usual and the FAB model was the long-term approach to thinking about a case rather than focusing on a particular incident of child maltreatment.

One county leader was concerned about the reductions in worker caseloads, and whether FAB caseworkers would have a steady flow of work during times when families were doing well and safety networks were in place. The other county leader stated that their county's biggest concern was whether they would have the resources to meet the basic needs of families, particularly in the long term. In addition, this county leader was concerned about the long-term sustainability of the program and how the county would secure funding to maintain their commitment to the caseload size required of FAB workers. Most of the other concerns from county leaders were related to the well-being of FAB workers and how they could best support them in managing an entire caseload composed of some of the counties' most difficult families to serve. These results provided important context into how FAB would require a different way of working with families and the concerns and expectations about the project up front.

During the training, community members observed the FAB intervention might give families an opportunity to have a long-term case manager who could maintain connections with all of the professionals involved in a family's life. Many were also hopeful that the FAB model would afford them more opportunities to collaborate on cases, although no clear protocol on how this would happen was identified. Several community members wanted to expand eligibility to more families—those *at risk* of chronic neglect (e.g., teenage mothers). Despite this interest, the project team determined that the eligibility criteria would not change at the outset of the project given each counties' capacity and the need to carefully pilot the project with the target population. Several staff voiced concerns about the length of time FAB cases would remain open, whether it was necessary and whether it would encourage families to become dependent on their worker or the system. Some county social service staff also questioned how FAB was actually different than business-as-usual, indicating many staff already have the flexibility to offer more intensive

case management where needed. They also followed up on the training topic of secondary trauma and the importance of self-care and expressed concern about how emotionally draining the work would be for FAB workers and how other staff could assist FAB workers. One worker suggested that, to inform the FAB model, families who are currently in the system be asked to describe what is missing in the FAB approach to working with them as compared to their past experiences with CPS workers (a suggestion later incorporated into the evaluation). Finally, some workers expressed concern about community partners' understanding of the model and the high expectations for what it might achieve; they indicated the need for a clear message to the community about what this intervention is and what it is not. FAB workers and supervisors recognized that such communication efforts should be careful not to stifle the positive energy of community partners.

FAB workers and supervisors also raised questions around how to meet demand for the program and help all eligible families if the program exceeded capacity, what kinds of flexible funds would be available to support families' basic needs and how the impact on family stability could be measured, what tools should be used for family assessment, the need to sustain service intensity once safety and stability have been established, and the case closure criteria. The resolution for many of these questions was, in part, to wait and see if and how these issues presented themselves during the pilot while initially implementing the model as designed. Many of these questions emerged later during the pilot phase when the FAB workers expressed the need for support and adjustments to the program model, and the project team discussed these issues in full during the consultation calls. Conversely, many of the concerns did not come to fruition at all (e.g., concerns about capacity). Overall, community members, supervisors, and program planners expressed high hopes and expectations for the project. FAB social workers, while also hopeful, were more guarded about their expectations for change given their previous experiences with similar families.

Regarding the online survey, over half (58 percent) of the respondents were community partners such as law enforcement, judicial staff, and school personnel; the remaining respondents were child welfare agency staff (16 percent working directly with the FAB intervention). The survey revealed that most respondents (87 percent) rated their level of understanding of the new FAB intervention as "somewhat well" or "well." The majority of respondents (61 percent) felt that the FAB model offered something new and different than their respective county's current response to chronic neglect. When asked to describe *how* the FAB model

differed, respondents noted the increased duration and/or intensity of contact with families, its proactive approach, smaller caseloads, and the increased collaboration among professionals. While a minority (39 percent) of respondents reported that they left the training with ideas about how to do their work differently to assist families experiencing chronic neglect, three of the five FAB workers said they left with ideas about how to better respond to chronic neglect cases. About two-thirds (68 percent) of respondents felt that the FAB intervention would lead to better outcomes for families.

The analysis of the interviews, observations of the trainings, and the online survey results revealed several important issues to be considered prior to the implementation of the FAB intervention. First, staff and community partners mentioned that it would be helpful to have clear and concise program materials for their own reference and to share with families; the project team provided FAB workers with a one-page description of the FAB intervention to help families understand service receipt and to ensure consistent implementation across the workers and counties. The results also revealed the need for more discussion about what the actual intervention would look like and the specific intervention strategies that would be used in working with the families. Lastly, the project team deemed it important to communicate with county staff, as well as community partners, about the intervention, how progress would be measured, and the results of evaluation activities. The information gained in this pre-implementation phase foreshadowed themes returned to in later phases of the evaluation, informed evaluation questions moving forward, and suggested that community and worker support for and understanding of the model was likely sufficient to proceed with implementation.

Early Implementation Results

Interviews with FAB workers, supervisors, and county leaders, as well as the content of the monthly consultation calls, revealed key themes pertaining to the first-year implementation of the model. FAB staff exhibited a common understanding of the model, though they continued to raise the point that many of the model elements were not dissimilar to current practice. For instance, child welfare agency leadership encouraged FAB workers to increase efforts to engage and involve community partners to meet the family's concrete needs; however, during the interviews, workers reported no difference in how they engaged with other professionals, internally and externally, compared to their work prior to FAB. While FAB staff later reported differences between the FAB model

and business-as-usual, the initial perception of a lack of difference could speak to the high quality of their social work practice, the need for more time to fully understand how the model works differently with families, and/or the need to further enhance the FAB model if more practice change is necessary to work effectively with these families.

Changes to the model. The consultation calls revealed low referrals and a slow start-up. While low referral rates when implementing a new intervention are not uncommon as referring staff become familiar with the availability of the new program, the lack of steady referrals also led to questions concerning the eligibility criteria for FAB. Many families seemed to fit the profile of families experiencing chronic neglect, yet their current report was not for neglect. This is consistent with the research showing that families experiencing chronic neglect often present over time with other maltreatment allegations (Loman, 2006). Further, a number of families did not meet the threshold for maltreatment substantiation and/or did not have the requisite number of prior maltreatment reports. Families who were referred to dependency court or drug treatment were also not eligible for the FAB intervention, as these families received services from other dedicated caseworkers. (The number of families excluded from FAB due to involvement in these other court systems was negligible and is not believed to have had a significant impact on referral rates.) As a result of the documentation around referrals and eligibility, the project team changed the eligibility criteria during the first year of implementation to raise the age limit for the child from five to seven and to include families whose current report was for maltreatment other than neglect, with the hope of increasing referrals without changing the other, more theoretically-based criteria.

Relaxing the eligibility criteria around maltreatment type for the current CPS report creates the possibility of incorrectly identifying families who should receive FAB (i.e., including families who are not chronically neglecting children). Evidence suggests, however, that the type of maltreatment report does not reliably predict subsequent report types, that report types within families often shift and more often shift from abuse to neglect, and that families with more reports of maltreatment have a greater proportion of reports for neglect (Loman, 2006). Considering this, and that over 60 percent of FAB-participating families had four or more prior reports to CPS, allowing families to receive FAB whose most recent reported maltreatment type was other than neglect was likely not misidentifying families appropriate for the intervention.

Later in the second year of implementation, several workers noted that they closed cases prior to the minimum 18 months of service delivery. Allowing the cases to close prior to 18 months of service delivery, however, challenged one of the central tenets of the intervention, which was that families who chronically neglect children require a significantly longer duration of services. In order to reconcile the model with practice, FAB staff, the program developer, and the evaluators discussed multiple factors to weigh when considering early case closure, including no new child maltreatment reports over a pre-determined time period, the length of maltreatment chronicity prior to FAB, and fewer requests for financial supports (as evidence of increased family stability). The project team developed five guiding questions to utilize when considering early case closure: (1) Is there an established safety network in place that is aware of the concerns and is committed to the children's safety and well-being through adulthood? (2) Does the safety network have a plan to intervene for the children if necessary? (3) Is the safety network confident in the plan that is developed? (4) Does the safety network have a plan to ensure the children's safety if the family distances themselves at some point after the social services case is closed? and (5) Has the size of the safety network improved over time given the nature of maltreatment chronicity? Based on the practice wisdom of FAB workers and program developer, these guidelines were established late in the final year of the process evaluation and, therefore, were not fully implemented or evaluated by the end of the pilot.

Challenges and benefits of more enduring and frequent contact with families. Workers noted that maintaining the required frequency of contact with families was difficult due to meeting cancellations by families, limited telephone access, travel time in large geographic areas, and the additional stressors that many families experienced (e.g., substance abuse, irregular employment hours, incarceration of other family members, child care). FAB workers struggled to meet these requirements due to other job demands and also expressed hesitancy to broach the topic of program intensity and the level of involvement with the families. Despite these difficulties, the workers reported that the increased frequency provided benefits to families. Some workers expressed that the increased contact helped establish better working relationships, which kept families engaged in the intervention and progressing toward their goals. The frequency of contact also increased the workers' exposure to informal supports, such as family members, friends, and neighbors who might be resources for the family. The

downside of this increased contact for some workers, as discussed on one consultation call, was the difficulty maintaining boundaries and the risk of getting pulled into family conflicts because of the workers' familiarity with the family dynamics.

The frequent contact and intervention length allowed for a more holistic approach, which is critical for working with families experiencing chronic neglect, since their needs are complex and multifaceted. Workers reported they addressed a broader spectrum of family issues, rather than just focusing on the issue that brought families to the attention of CPS. Workers also made more referrals to other types of services (e.g., parenting education, housing resources, basic needs) and had the time to help families follow through on these referrals.

> *In a typical case, the way child welfare works is we are looking at a very short period. We have workers that work on very specialized functions, and if a case isn't successful there, they might transfer to another area. So systemically we think short term, because cases usually transition. But, for FAB cases, we know we'll be with the family for the life of the case, so we have to do more planning for different types of outcomes.*
>
> *—Excerpt from an interview with a child welfare agency supervisor*

Workers also reported that the frequency of the visits allowed families to manage a few goals at a time (e.g., making a medical appointment or addressing a child's school needs) rather than attempting to accomplish a wide variety of changes during long periods between worker visits as was previously the case. Successfully achieving smaller, manageable goals are important stepping stones to reaching longer-term goals and are concrete evidence of a family's progress.

> *[With regular services], I would normally have two visits per month with case assessment. With FAB, I have 6-10 visits per month… A lot of what we do is dissecting and slowing things down. I think I've created a good partnership with the families.*
>
> *—Excerpt from a consultation call with a FAB worker*

Supervisors stressed the importance of helping workers see the benefits of this level of contact rather than focusing on the specific

requirements of meeting with families twice a week. Overall, staff felt that the FAB intervention was having a positive impact on families who were willing to engage in services and that having more time with the families had numerous positive benefits.

Using a strengths-based approach. During the consultation calls, staff reported adhering to the model by using solution-focused and strength-based interactions, which fostered a positive rapport with families. Some of these families had adversarial relationships with social workers in the past, and this approach helped the workers overcome families' trepidation. Some staff struggled to reconcile the strength-based approach with the family functioning assessments they were using, which tended to focus more on specific incidences and problems. Further, the intensity of the work and feelings of being overburdened led some FAB workers to honestly report on the difficulty of maintaining a strengths-based approach. Similarly, the possibility of burnout and secondary trauma of workers was an ongoing focus of discussion during the consultation calls, often raised by FAB workers themselves or broached by the program developer.

Staff characteristics for success. During the interviews, Wilder staff asked FAB workers and supervisors to reflect on the skills needed to be successful in working with families experiencing chronic neglect. Several staff reported that successful workers must have a solid knowledge of available community resources and the ability to develop relationships and think creatively. Workers commented that this work required patience, compassion, perseverance, tolerance, and flexibility. Several staff noted that workers implementing the FAB intervention cannot be easily discouraged and must be comfortable with slow, incremental change.

Secondary program benefits. Staff also identified several secondary benefits of the FAB model. The intervention raised other staff members' awareness of chronic neglect throughout the agency, and supervisors and county leaders began to incorporate elements of the FAB intervention into other work units. One county supervisor asked other workers in her unit to consider taking cases from intake to closure rather than transferring cases after the assessment phase, while another supervisor noted that other, non-FAB child welfare workers began implementing the frequency of contact guidelines of the model with their own cases.

Final Pilot Year: Participant Satisfaction, Fidelity, and Early Outcomes

The final phase of the evaluation gathered information about the implementation and perceived impact of the FAB model from the perspective of the parents who participated. Given that this was the first time this model has been tested in the field, participant satisfaction is necessary to assess before proceeding to other outcomes more focused on impact. Additionally, the project team examined outcomes related to child welfare involvement from all families participating in FAB. Since the families' relationship with the worker is at the heart of the FAB intervention, most of the parent satisfaction and fidelity measures focused on parents' perception of the workers.

Characteristics of families participating in the FAB intervention. Between February 2011 and November 2012, 18 families participated in the FAB intervention; the tracking log provided information on all of the families. Of these families, only three reached 18 months of service delivery and five families had their cases with the FAB intervention closed early due to case transfer, moving out of the county, or the family showing enough progress. By the cut-off date for the pilot evaluation (November 2012), families had, on average, received just over 12 months of the intervention (*SD*=5.5 months).

Families averaged 5.3 CPS maltreatment reports prior to the intervention (*SD*=3.3), 2.8 children in the home (*SD*=2.0; ranging from one child to nine children), and two adults in the household (with four single-adult households). The 51 children in the families ranged in age from a few months old to 16 years of age; the average age for a child among the FAB-participating families was six years old (*SD*=4.2; median age was five years old). The majority of parents in the household were birth mothers, all but one were white (consistent with county demographics), and two-thirds of the families received public assistance.

Participant satisfaction. Parents were eligible to participate in the telephone interviews if they had an open FAB case as of September 2012 or if their FAB case had recently closed. Based on these criteria, a total of 14 parents were eligible to participate in the interviews. The project team asked FAB social workers to contact parents, explain the study, and obtain verbal consent to share the parents' contact information with the researchers. All parents were given another opportunity to opt out of the interview at the time they were contacted by telephone. Workers or their

supervisors reached out to 13 parents in all (one parent was excluded due to worker concerns about the parent's emotional capacity to participate in an interview). Of the 13 parents contacted, nine completed an interview and one completed half an interview (eight mothers and two fathers) for a response rate of 77%. Research staff made a minimum of 15 attempts by phone to reach the three parents who did not ultimately participate. All respondents who participated in the interview received a $25 gift card to a department store.

Most parents described their relationship with their FAB worker in very positive terms. Parents reported that their worker was helpful, resourceful, and able to connect him or her to resources within the community. A few parents felt their relationship was "rocky" initially and wished that workers had listened to their perspective more at the outset. (Even these parents, however, went on to describe how the relationship improved over time.) Many parents used terms such as "caring", "concerned", "friendly", and "understanding" to describe their worker. Furthermore, several appreciated that workers seemed non-judgmental and genuine in their concern for the well-being of the family. Every parent interviewed said they felt their FAB worker was upfront with them and honestly conveyed the family's strengths as well as the concerns he or she had about the family. Most also said they felt they could be straightforward and honest with their worker in return and could talk about "almost anything." Parents generally felt connections to resources and concrete supports were the most helpful or valuable aspects of the FAB intervention (e.g., job opportunities, parenting classes, community activities, mental health services).

> *(He/she) has been a wonderful help for me. At first, I thought getting CPS called on me was a punishment, but (he/she) has been a real blessing, helping me to see that me and my (child) are taken care of.*
>
> *—Excerpt from an interview with a FAB-participating parent*

For the most part, parents described having a better relationship with their FAB worker compared to previous CPS workers because the FAB worker took the time to get to know them, cared about them, and listened to them. One parent noted how her FAB worker recognized her strengths, while another described how her FAB worker was giving her a chance to succeed. Several parents specifically mentioned making more progress this time with their FAB worker than with previous CPS workers.

In general, FAB workers were perceived to be forthright and resourceful, while past workers were described as being poor communicators, impatient, and little help in finding services and resources. These findings are consistent with parents' responses to closed-end questions asking parents to rank their FAB worker as well as past workers (as a whole) on a scale from 0 to 10, with 0 indicating a worker who was *not at all* helpful, positive, honest, or respectful and 10 indicating a worker who was *very* helpful, honest, positive, or respectful. FAB workers received ratings ranging from 6 to 10, with an average rating of 8.2 (*SD*=1.6). In contrast, past workers received ratings ranging from 0 to 10, with an average rating of 4.1 (*SD*=3.8). In only one instance did a parent rate previous workers higher than his or her FAB worker. This parent appreciated that past workers did what they said they were going to do "and then were done" and suggested her FAB worker could be more compassionate and understanding.

Fidelity. The majority of parents reported having had more contact with their worker through the FAB intervention than with a typical CPS response. Specifically, seven of nine parents reported at least two contacts per week with their FAB worker. Parents acknowledged that this level of interaction with their worker was somewhat intense and expressed mixed feelings about the increased level of contact. One parent reported they would improve the FAB model by ending the case more quickly, though another parent remarked that he/she "wished it had been longer."

> *Sometimes [the amount of contact] is frustrating. It sometimes seems [the worker] is being nosy. I understand that s/he is concerned about [my child's] welfare, but I don't think it warrants seeing [my child] every week. But [the worker] is now here more for support services than for actual child welfare…. It has [been helpful], looking back. It is helpful to stay in touch so frequently with us, because things change so quickly, with so many things going on in our lives.*
>
> *—Excerpt from an interview with FAB-participating parent*

Research staff also used a series of closed-ended questions to assess fidelity to the model as pertaining to the qualities and characteristics of workers (see Table 2). Almost all parents (eight out of nine) felt workers were honest, committed to keeping their children safe, helped them find community resources, and worked on goals they thought

were achievable. Parents were somewhat less likely to feel that workers understood their struggles as a family or treated them as a partner in deciding what was best for their children (only four of the nine parents responded these statements were "always true"). Two parents also thought that workers were not sensitive to their family's culture.

Table 2: Parent satisfaction with the FAB worker/experience (n=9)

Your current caseworker…	*Always true*	*Sometimes true*	*Not true at all*
…is committed to keeping your child(ren) safe.	89%	11%	0%
…is honest with you.	89%	11%	0%
…is working on goals that you think are achievable.	89%	11%	0%
…helps you reach out to community resources or other family members for support.	89%	0%	11%
…has helped you obtain services that you need.	78%	22%	0%
…is focused on solutions to the challenges you face.	78%	22%	0%
…recognizes your family's strengths.	67%	33%	0%
…asks for your input on decisions about your family.	67%	33%	0%
…is sensitive to your family's culture.	67%	11%	22%
…is flexible.	56%	33%	11%
…understands the particular struggles you face as a family.	44%	44%	11%
…treats you as a partner in deciding what's best for your child(ren).	44%	44%	11%

Note. Items were reordered from highest to lowest level of endorsement for the purposes of this table.

Early outcomes. All parents expressed optimism about the future, felt like things were moving in the right direction for their family, and planned to continue to work on the issues they had been addressing. A couple of parents described the concrete changes they had made (i.e., parenting improvements, sobriety, implementing specific safety precautions) and their confidence in the positive effect said changes would have. One parent, however, still expressed concern about her child being removed from her home. Parents also ranked, on a scale from 0 to 10, their confidence that there would be no future CPS reports, with 0 indicating no confidence at all and 10 indicating total confidence. The average score was 8.3 (*SD*=2.0).

For the 51 children whose families were served through the FAB intervention, a total of 25 re-reports of maltreatment were filed with CPS on 13 children during their involvement with the program (68 percent of which were filed during the first six months of the intervention). CPS found six re-reports to be substantiated (for six different children), five of which occurred within 12 months of the initial substantiated report (a rate of 9.8 percent). For comparison, in one participating county, the rate of subsequent substantiated maltreatment reports overall within 12 months was 5.8 percent the year prior to FAB implementation and 11.3 percent during the first year of the FAB intervention (County agency representative, personal communication, October 29, 2014). Thirteen children were placed out-of-home during or following the intervention, with most placements occurring more than 12 months after the start of FAB. For the families with subsequent reports or children placed out-of-home, ongoing CPS involvement and child placements varied. Families with a subsequent substantiated report either declined further services, moved out of the county, or had their case transferred to another caseworker or program. Children placed out-of-home were either returned to their parent's custody after a few months, were awaiting the results of a permanency petition at the time of this study, or were placed permanently with a relative. When examining ongoing child welfare involvement, which the intervention model is designed to address, it is important to keep in mind that this information is descriptive only, and a comparison group design was not used for this stage of the evaluation. Second, these are point-in-time estimates and due to the nature of ongoing enrollment, families had different lengths of involvement with FAB.

These child welfare measures of ongoing involvement paint a sobering picture, somewhat contrary to the expectations of staff and families as reported in the qualitative interviews. While the intervention itself may or may not be effective in interrupting the chronic nature of neglect in these families, a high level of ongoing child welfare involvement would be predicted in its absence. It may be that FAB resulted in greater surveillance, which would increase the likelihood of maltreatment allegations relative to otherwise similar families who are not as engaged with services. Conversely, as a result of their closer relationship with the FAB worker, families may have been initiating a request of assistance from CPS themselves, reflecting an increased understanding of when they need assistance and comfort with the child welfare system. It may also be the case that interventions and community supports needed to be in place earlier to assist these families.

Recommendations

The evaluation of FAB suggests that, in general, the model is working as designed and FAB workers, through a combination of selection for the project, training, and the ongoing consultation calls generally embody the values and principles of the model. The information collected from the consultation calls and interviews informed model development in several ways and will be useful information for any replication efforts. For example, future iterations of programs addressing chronic neglect should consider developing formal arrangements with community service providers to enhance the model framework. Another consideration for any replication effort would be to carefully consider and monitor eligibility requirements relative to project capacity. Further, assessment tools should be examined for their alignment with some of the strength-based components of the model.

As part of an intervention development approach, the evaluation of program implementation can serve in a performance monitoring capacity as well. Evaluation results from the early phases of FAB implementation were used iteratively to provide feedback to the caseworkers, improve practice, and adjust the FAB model specifications; Fixsen et al. (2005, p. 30) emphasize that feedback loops such as this can help retain the core components of an intervention while incorporating the modifications necessary to improve program effectiveness. Specific changes made to the FAB model during the early implementation phase included expanding the eligibility criteria to include families whose youngest child in the home was age seven or younger, including families whose *current* report was for maltreatment other than neglect, and relaxing the program duration based on newly-developed case closure criteria. These adjustments marginally increased the number of referrals and allowed families to close cases prior to completing the 18-month service duration, while maintaining the core components of service intensity (meeting frequency), a family strengths focus, short-term goal setting, and dedicated staffing.

As a solution to the nature and intensity of the work, workers suggested assigning cases incrementally as workers get comfortable and familiar with the dedicated focus and requirements of the intervention. Additional recommendations stemming from these results included teaming workers to share the workload and provide support, developing concrete tools for working with families, and providing ongoing training, on-site coaching, and field observations to increase the skill and confidence of the workers, supervisors, and county leaders. Additional training topics suggested by staff included working with demoralized parents, maintaining hope, secondary trauma, maintaining worker-client

boundaries, motivational interviewing, family engagement, and crisis management. Workers also noted that there is a need to document aspects of the intervention that make it unique from business-as-usual and boosting evaluation efforts to increase buy-in.

Study Limitations

This study was designed to facilitate learning around the development and implementation of a new program model serving families who chronically neglect their children. While the findings above are essential to understand the challenges in working with this population and the critical components needed for program success, the lessons learned from the study's limitations can be equally as enlightening for the development of new program models. For example, the intervention selection criteria may have been too restrictive to achieve the desired number of referrals to FAB. The inability of the counties to access the full extent of a family's history with CPS *outside* of their respective jurisdictions exacerbated the difficulty finding families who met FAB eligibility as well. Thus, the findings from these evaluation results may not be representative and should be interpreted cautiously given the small sample size (18 families). This same caution extends to the survey results, where 13 families were eligible to complete the survey and only 10 participated.

The low rate of referral to FAB should be examined to make sure the intervention is adequately serving the target population. Research demonstrates that a high degree of variation exists in referral rates to programs and services based on a number of family and agency characteristics (Jud, Fallon, & Trocmé, 2012), from caseworker resistance to the implementation of a new practice model (Dewey, Tipon, DeWolfe, Sullins, & Park, 2014) to concerns over levels of caregiver functioning (Fallon, 2005). When the FAB intervention began, the agencies stopped coming across as many families with a sufficient history of referrals to CPS to qualify for FAB; in fact, one county reported a nearly 30 percent decrease in the number of families reported with two or more child protection assessments from the years prior to FAB to the years during and following FAB implementation (County agency representative, personal communication, October 29, 2014), though the reasons for this trend cannot be determined by these data. Given the percentage and number of maltreatment reports screened in for neglect and the number of families with multiple prior maltreatment reports in the participating counties, the low rate of referrals appears not to imply a lack of need for

this type of intervention, rather it implies the need for more flexible eligibility criteria or enrollment on a case-by-case basis.

The inability of caseworkers to meet with families with the frequency outlined by the intervention components (i.e., two contacts per week with the primary caregiver) challenged fidelity to the program model; this was in large part due to family scheduling conflicts and resource constraints. Fidelity related to service delivery duration was also challenged due to families' cases transferring across programs or workers and by families moving out of the county (out of the catchment area of the intervention). Because FAB caseworkers both administered the intervention and reported on the implementation outcomes, the possibility exists that the evaluators received biased feedback and information. To reduce the risk of bias, the evaluators collected supplementary fidelity measures through the participant interviews and surveys; further, FAB workers were quite candid about their difficulties maintaining model fidelity throughout the implementation and the evaluators encouraged this kind of feedback for the purposes of the project and the development of the intervention.

The preliminary outcomes from FAB represent point-in-time measures for a select group of families in two Minnesota counties. With a longer time frame for referrals, program completion, and outcomes measurement, the results of this study might look significantly different. Given the small number of families served and the localized context of the FAB implementation, the results presented here may not be wholly generalizable to all families experiencing chronic neglect or the interventions developed to serve them.

Finally, the implementation of FAB used an intervention development approach, and county agencies and the program developer allowed the FAB eligibility criteria to shift according to need. For this and other reasons related to the methodological appropriateness of the evaluation relative to the stage of development of the intervention, this evaluation of the program model cannot draw conclusions around the effectiveness of FAB. Without a comparison group, the impact of the model on ongoing child welfare involvement cannot be determined. The next stage in model development would be to test the model and its core components on a larger-scale and use an experimental or quasi-experimental design for comparison purposes.

Discussion and Conclusion

Neglect continues to be the most pervasive form of child maltreatment in the United States, which is especially disconcerting given

the deleterious and lasting effects that neglect can have on child development and later life outcomes. Chronic neglect, in particular, can be especially devastating as repeated, prolonged exposure to neglect increases the risk of negative outcomes for children. These distressing facts and the relative dearth of interventions designed specifically to address chronic neglect, led to the development and implementation of the Family Asset Builder. This article describes the intervention and how the project team used a corresponding evaluation, appropriate to the developmental phase of the intervention, to inform its development, implementation, and possible replication. Based on the implementation science literature and the framework for replicating effective programs (Kilbourne, Neumann, Pincus, Bauer, & Stall, 2007), early stages of evaluation in the intervention development approach were critical for understanding the strengths and limitations of FAB before resources were invested in the model's spread and replication.

This study utilized an evaluation approach that draws on many of the fundamental components of project-level evaluation (see Millett et al., 1998 for a review), such as revising methods based on early evaluation results, establishing a flexible and responsible design, learning from community engagement, and gathering multiple perspectives. For example, the engagement of community members prior to the implementation of the intervention highlighted potential resource deficiencies and issues with sustainability, the need to address potential secondary trauma of FAB workers, and the need for clarity around the FAB model's core components before the intervention was rolled out. In addition, the results from early phases of the FAB evaluation informed the design and content of later phases. This kind of evaluation approach requires patience, especially in terms of delaying investment in a rigorous outcome evaluation until information is collected on whether the model is implemented as planned and/or necessary adjustments are made, whether the consumers of the model are satisfied, and whether evidence accumulates that the model shows promise.

By involving multiple stakeholders in the evaluation design and process (funders, workers, and program developers) and collecting information from multiple perspectives (training participants, county leaders, supervisors, workers, and parents), the project evaluators ensured that the timeliness and usability of the results were maximized. Ongoing consultation, continuous self-reflection, and transparency between all parties involved guided the intervention development and refinement to make it more relevant, applicable, and effective for the families involved, consistent with an implementation framework for

effective intervention deployment (Fixsen et al., 2005; NAMHC, 2001). This continuous process allowed the researchers to identify the training and consultation needs of the FAB workers and validated the fidelity of the model as it applied to worker characteristics. Researchers shared evaluation results with FAB staff at each phase, the program developer and child welfare agency staff made adjustments to the model implementation immediately, and the project team crafted recommendations collectively based on what was being learned.

Apart from the shift in eligibility criteria, the consultations with FAB staff highlighted the difficulties workers faced maintaining the necessary frequency of contact with participating families while illuminating the many benefits of increased contact. Child welfare staff discovered that the strengths-based approach was instrumental for establishing rapport with FAB-participating families, and that this approach may be one of the mechanisms by which families can achieve meaningful and lasting behavioral change. The interviews with families suggest workers generally embodied the critical components of the FAB intervention and that more progress may have been achieved from working with FAB workers than with other CPS workers in the past, largely due to the openness of communication, the genuine and honest rapport established through sustained contact, and the provision of concrete supports by FAB workers.

Unfortunately, resource constraints following the recession did not allow either county to retain the dedicated and lower caseload required by FAB. Nonetheless, this implementation and associated evaluation certainly point to some characteristics of workers and specific strategies that could be incorporated into everyday practice to make working with this population more successful. Chronic neglect is a widespread issue causing a tremendous and disproportionate burden on public child welfare systems, with significant costs attached (Chaffin et al., 2011; CWIG, 2013). More importantly, the long-term detrimental impacts on children, including the accumulation of toxic stress associated with repeated failure to have their basic developmental needs met, points to the urgency for the field to better address the needs of families who are consistently coming to the attention of child welfare systems for neglect.

References

Adams, R. (2003). *Social work and empowerment*. Basingstoke, UK: Palgrave Macmillan.

Alameda-Lawson, T., Lawson, M. A., & Lawson, H. A. (2013). An innovative collective parent engagement model for families and neighborhoods in arrival cities. *Journal of Family Strengths*, *13*(1), 1-25.

Altshuler, S. J., Cleverly-Thomas, A., & Murphy, M. A. (2009). "Whatever it takes": Illuminating a new promising practice for responding to chronic neglect. *Protecting Children*, *24*, 78-88.

American Humane Association. (2010, September). *Child welfare policy briefing: Chronic neglect*. Retrieved from http://www.americanhumane.org/assets/pdfs/children/adv-policy-briefing-chronic-neglect.pdf

Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report, 2*(1). Retrieved from http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html

Australian Office for Children, Youth and Family Support, Community Services Directorate. (2010, October). *Focus on neglect*. Canberra, Australia: Author.

Bath, H. I., & Haapala, D. A. (1993). Intensive family preservation services with abused and neglected children: An examination of group differences. *Child Abuse and Neglect*, *17*(2), 213-225.

Britt, H., & Coffman, J. (2012). *Evaluation for models and adaptive initiatives.* The Foundation Review, 4, 2, 44-58.

California Evidence-Based Clearinghouse for Child Welfare. (2014). *Topic: Interventions for neglect*. Retrieved from http://www.cebc4cw.org/topic/interventions-for-neglect/

Cameron, G., & Vanderwoerd, J. (1997). *Protecting children and supporting families: Promising programs and organizational realities*. New York, NY: Aldine de Gruyter.

Carter, V., & Myers, M. R. (2007). Exploring the risks of substantiated physical neglect related to poverty and parental characteristics: A national sample. *Children and Youth Services Review*, *29*(1), 110-121.

Chaffin, M., Bard, D., Hecht, D., & Silovsky, J. (2011). Change trajectories during home-based services with chronic child welfare cases. *Child Maltreatment*, *16*(2), 114-125.

Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics*, *129*(3), 509-515.

DOI: 10.58464/2168-670X.1244

Child Welfare Information Gateway. (2012). *Acts of omission: An overview of child neglect.* Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau.

Child Welfare Information Gateway. (2013). *Chronic child neglect.* Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau.

Copps Hartley, C. (2002). The co-occurrence of child maltreatment and domestic violence: Examining both neglect and child physical abuse. *Child Maltreatment*, *7*(4), 349-358.

Daro, D. (2009). The history of science and child abuse prevention: A reciprocal relationship. In K. A. Dodge & D. L. Coleman (Eds.), *Preventing child maltreatment: Community approaches* (pp. 9-28). New York, NY: Guilford Press.

DePanfilis, D. (2006). *Child neglect: A guide for prevention, assessment, and intervention*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

DePanfilis, D., & Dubowitz, H. (2005). Family Connections: A program for preventing child neglect. *Child Maltreatment*, *10*(2), 108-123.

DePanfilis, D., & Zuravin, S. J. (1998). Rates, patterns, and frequency of child maltreatment recurrences among families known to CPS. *Child Maltreatment*, *3*, 27-42.

DePanfilis, D., & Zuravin, S. J. (1999). Epidemiology of child maltreatment recurrences. *Social Service Review, 73*, 218-239.

Dewey, J., Tipon, G., DeWolfe, J., Sullins, C., & Park, C. C. (2014). The path from process to outcomes: A cross-site evaluation of 24 Family Connection grantee projects. *Child Welfare*, *92*(6), 9-39.

Dubowitz, H. (1994). Neglecting the neglect of neglect. *Journal of Interpersonal Violence*, *9*(4), 556-560.

Ethier, L. S., Couture, G., Lacharite, C., & Gagnier, J.-P. (2000). Impact of a multidimensional intervention programme applied to families at risk for child neglect. *Child Abuse Review*, *9*(1), 19-36.

Erickson, M. F., & Egeland, B. (2002). Child neglect. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 3-20). Thousand Oaks, CA: Sage.

Fallon, B. (2005). *Factors driving case dispositions in child welfare services: Challenging conventional wisdom about the importance of organizations and workers*. Toronto, Canada: University of Toronto.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Gardner, R. (2008, January). *Developing an effective response to neglect and emotional harm to children.* Norwich, England: University of East Anglia and the National Society for the Prevention of Cruelty to Children.

Gaudin, J. M., Jr. (1999). Child neglect: Short-term and long-term outcomes. In H. Dubowitz (Ed.), *Neglected children: Research, practice, and policy* (pp. 89-108). Thousand Oaks, CA: Sage.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet*, *373*(9657), 68-81.

Hearn, J. (2011). Unmet needs in addressing child neglect: Should we go back to the drawing board? *Children and Youth Services Review*, *33*(5), 715-722.

Hildyard, K. L., & Wolfe, D. A. (2002). Child neglect: Developmental issues and outcomes. *Child Abuse & Neglect, 26*, 679-695.

Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277-1288.

Institute of Medicine. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy of Science.

James Bell Associates. (2009, October). *Evaluation brief: Measuring implementation fidelity*. Arlington, VA: Author.

Jud, A., Fallon, B., & Trocmé, N. (2012). Who gets services and who does not? Multi-level approach to the decision for ongoing child welfare or referral to specialized services. *Children and Youth Services Review*, *34*(5), 983-988.

Kaplan, C., Schene, P., DePanfilis, D., & Gilmore, D. (2009). Introduction: Shining light on chronic neglect. *Protecting Children*, *24*(1), 1-8.

Kilbourne, A. M., Neumann, M. S., Pincus, H. A., Bauer, M. S., & Stall, R. (2007). Implementing evidence-based interventions in health care: Application of the replicating effective programs framework. *Implementation Science*, *2*(42), 1-10.

Klevens, J., & Whitaker, D. J. (2007). Primary prevention of child physical abuse and neglect: Gaps and promising directions. *Child Maltreatment*, *12*(4), 364-377.

Loman, L. A. (2006, February). *Families frequently encountered by child protection services: A report on chronic child abuse and neglect*. St. Louis, MO: Institute of Applied Research.

Macdonald, G. (2001). *Effective interventions for child abuse and neglect: An evidence-based approach to planning and evaluating interventions*. Chichester, West Sussex, United Kingdom: John Wiley & Sons.

Marshall, D. B., & English, D. J. (1999). Survival analysis of risk factors for recidivism in child abuse and neglect. *Child Maltreatment*, *4*(4), 287-296.

McCann, L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of work with victims. *Journal of Traumatic Stress*, *3*(1), 131-149.

Miller-Perrin, C. L., & Perrin, R. D. (2013). *Child maltreatment: An introduction* (3rd ed.). Thousand Oaks, CA: Sage.

Millett, R. A., Curnan, S., LaCava, L., Langenburgm D., Lelle, M., & Reece, M. (1998). *W. K. Kellogg Foundation evaluation handbook: Philosophy and expectations*. Battle Creek, MI: W. K. Kellogg Foundation.

National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. (2001). *Blueprint for change: Research on child and adolescent mental health*. Washington, DC: National Institute of Mental Health.

National Scientific Council on the Developing Child. (2012). *The science of neglect: The persistent absence of responsive care disrupts the developing brain: Working paper 12*. Retrieved from http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp12/

Nelson, K. E., Saunders, E. J., & Landsman, M. J. (1993). Chronic child neglect in perspective. *Social Work*, *38*(6), 661-671.

Osofsky, J. D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment. *Clinical Child and Family Psychology Review*, *6*(3), 161-170.

Pekarsky, A. R. (2014, June). Overview of child maltreatment. In *The Merck manual*. Retrieved from http://www.merckmanuals.com/professional/pediatrics/child_maltreatment/overview_of_child_maltreatment.html#top

Perry, B. D. (2001). The neuro-archeology of childhood maltreatment: The neuro-developmental costs of adverse childhood events. In K. Franey, R. Geffner, & R. Falconer (Eds.), *The cost of child*

maltreatment: Who pays? We all do (pp. 15-37). San Diego, CA: Family Violence & Sexual Assault Institute.

Shook Slack, K., Holl, J., McDaniel, M., Yoo, J., & Bolger, K. (2004). Understanding the risks of child neglect: An exploration of poverty and parenting characteristics. *Child Maltreatment*, *9*(4), 395-408.

Smith, M. G., & Fong, R. (2004). *The children of neglect: When no one cares*. New York, NY: Brunner-Routledge.

Steib, S., & Blome, W. W. (2009). How can neglected organizations serve neglected children? *Protecting Children, 24*(1), 9-19.

Turney, D., & Tanner, K. (2001). Working with neglected children and their families. *Journal of Social Work Practice*, *15*, 193-204.

Tyler, S., Allison, K., & Winsler, A. (2006). Child neglect: Developmental consequences, intervention, and policy implications. *Child & Youth Care Forum, 35*(1), 1-20.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2000). *Child maltreatment 2000*. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2011). *Child maltreatment 2010*. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child maltreatment 2012*. Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

Wilson, D. & Horner, W. (2005). Chronic child neglect: Needed developments in theory and practice. *Families in Society, 86*, 471-481.

Zuravin, S. J., & DePanfilis, D. (1996). *Child maltreatment recurrences among families served by Child Protective Services: Final report to the National Center on Child Abuse and Neglect*. Washington, DC: National Center on Child Abuse and Neglect.